Tommy G. Thompson Governor

Gerald Whitburn Secretary



State of Wisconsin

Department of Health and Social Services

DIVISION OF HEALTH

1 WEST WILSON STREET P. O. BOX 309 MADISON WI 53701-0309

MEMORANDUM

DATE:

April 18, 1994

TO:

All Wisconsin Medical Assistance Certified Medical Day Treatment Providers

FROM:

K. B. Piper, Director

Bureau of Health Care Financing

RE:

Wisconsin Medical Assistance Provider Handbook, Part H, Division III

Enclosed is the first issue of the Wisconsin Medical Assistance Provider Handbook, Part H, Division III, for medical day treatment services.

Future updates to this handbook may occur either as replacement pages or as a complete revision, depending on the frequency and volume of changes. Upon receipt, all updates should be recorded on the Transmittal Log and inserted into the appropriate area of the handbook.

Please note that all providers must use the claim sort indicator "P" when submitting claims. This is only a change for those programs that are board owned and operated. Refer to Appendix 2 of this handbook for more information.

I hope you find this handbook helpful in getting your claims paid quickly and efficiently and in resolving any billing problems you may encounter. As you use this handbook, you may find sections which are unclear or things we have forgotten. Please share your ideas with us on how we can improve this and any other area of provider communications.

We appreciate the services you provide to Wisconsin residents and thank you for participating in the Wisconsin Medical Assistance Program.

KBP:dd PC03136.CW/HB

Enclosure

PART H, DIVISION III MEDICAL DAY TREATMENT TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part H, Division I, of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

If a provider is missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 3H-3 and you receive 3H-5, you are missing 3H-4. If a provider is missing a transmittal, copies of <u>complete</u> provide handbooks may be purchased by completing the form in Appendix 36 of Part A of the WMAP Provider Handbook.

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Number	Initials	Issue Date
		
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WMAP Provider Handbooks, Part H, Division III

Issued: 04/94

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP provider handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

<u>Part A</u> of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The <u>service specific</u> part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by completing the form in Appendix 36 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental) and document number.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of Part A of the handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

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PART H, DIVISION III	SECTION I	ISSUED	PAGE
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A. TYPE OF HANDBOOK

Part H, Division III, Adult Medical (Mental Health) Day Treatment Services, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division III, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Use Part H, Division III in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of Wisconsin Medical Assistance Program (WMAP) providers.

Providers who are also certified to provide other WMAP covered mental health or alcohol and other drug abuse (AODA) services should refer to the appropriate service specific handbooks for information on those services. Part H, Division I is for use by Non-51.42 Board-Owned-and-Operated Clinics providing mental health and AODA services. Part H, Division II is for use by 51.42 Board-Owned-and-Operated Clinics providing mental health and AODA services. Part H, Division IV is for AODA Day Treatment Providers. Part H, Division V is for Community Support Program (CSP) providers. Separate certification is required for each of these programs. The provider should contact EDS for certification materials.

B. PROVIDER INFORMATION

Provider Eligibility and Certification

In order to be certified as a WMAP Medical Day Treatment provider, all of the following requirements must be met:

- The provider is certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the day treatment requirements under HSS 61.75, Wis. Admin. Code. To obtain information on certification under HSS 61.75 providers must contact:

Program Certification Unit Division of Community Services Post Office Box 7851 Madison, WI 53707 (608) 266-0120

- The day treatment program is planned for and directed by designated members of an interdisciplinary team that includes a social worker, a psychologist, an occupational therapist, a registered nurse or a physician, physician's assistant, or another appropriate health care professional.
- A registered nurse and a registered occupational therapist (OTR) are on duty to participate in program planning, program implementation, and daily program coordination.
- For purposes of daily program performance, coordination, guidance, and evaluation, each group is staffed by one qualified professional staff member such as an OTR, masters degree social worker, registered nurse, licensed psychologist or masters degree psychologist, or one certified occupational therapy assistant and one other paraprofessional staff person.
- A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team is made at least every 60 days.

A provider meeting these eligibility requirements for medical day treatment who wishes to be certified as a WMAP medical day treatment provider must contact:

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PROVIDER B. **INFORMATION**

(continued)

EDS

Attn: Provider Maintenance

6406 Bridge Road

Madison, WI 53784-0006

Providers are required to submit a copy of the approval letter from DCS to verify that they have been certified as a medical day treatment program under HSS 61.75, Wis. Admin. Code. Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit to ensure the earliest possible certification effective date.

Scope of Service

The policies in Part H, Division III govern services provided within the scope of the practice as defined in HSS 107.13 (4), Wis. Admin. Code. Covered services and related limitations are given in Section II of this handbook.

Reimbursement

Medical day treatment providers are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established for that provider by the DHSS. The maximum allowable fee is a comprehensive hourly rate which is paid for any allowable day treatment services regardless of which staff person(s) provided the service or whether the service provided was a group or individual service. Providers who want the maximum allowable fee established for their program should contact:

> Mental Health/AODA Policy Analyst Bureau of Health Care Financing Division of Health Post Office Box 309 Madison, WI 53701

Provider Responsibilities

Specific responsibilities as a WMAP provider are stated in Section IV of Part A of the WMAP Provider Handbook. Reference Section IV of Part A for detailed information regarding:

- fair treatment of the recipient;
- maintenance of records;
- recipient requests for noncovered services;
- services rendered to a recipient during periods of retroactive eligibility;
- grounds for provider sanctions; and
- additional state and federal requirements.

RECIPIENT C. INFORMATION

Eligibility For Medical Assistance

Recipients eligible for Medical Assistance receive Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage.

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C. RECIPIENT INFORMATION (continued)

Recipients receive Medical Assistance identification cards on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine the recipient's eligibility and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and eligibility verification. Review Section V of Part A carefully before rendering services. A sample Medical Assistance identification card is found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of Part A of the WMAP Provider Handbook for additional medical status information.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining medical day treatment services. The procedure codes and their applicable copayment amounts are in Appendix 4 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.
- Services provided to a pregnant woman if the services are related to the pregnancy.
- Services covered by a WMAP-contracted managed care program to enrollees of the managed care program.
- Family planning services and related supplies.

Copayment is collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from WMAP payments. Do not reduce the billed amount of the claim by the amount of recipient copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. The codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

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C. RECIPIENT INFORMATION (continued)

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for medical day treatment services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

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A. INTRODUCTION

Day treatment or day hospital means a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances. Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills (HSS 101.03 (37) Wis. Admin. Code).

Adult medical day treatment services are covered for recipients who are 18 years of age or older. Refer to Section II-D of this handbook for information about day treatment services for individuals under the age of 18.

B. COVERED SERVICES

Requirements for Medical Day Treatment Services

Pursuant to HSS 105.24 and HSS 107.13(4), Wis. Admin. Code, medical day treatment services are a covered benefit when the following conditions are met:

- a physician prescribes the services in writing;
- the provider is certified by the Wisconsin Medical Assistance Program (WMAP) as described in Section I of this handbook;
- before becoming involved in the day treatment program, the recipient is evaluated through the use of the functional assessment scale provided by the department to determine the medical necessity for day treatment and the person's ability to benefit from it (refer to Appendices 11 and 12 of this handbook for instructions on the completion of the functional assessment and a sample functional assessment form);
- a treatment plan is developed, based on the initial evaluation, and includes measurable, individual goals, the specific treatment modalities, including identification of the specific group or groups, to be used to achieve these goals, and the expected outcomes of treatment;
- each group is led by a qualified professional staff person (i.e. a registered occupational therapist [OTR], masters degree social worker, registered nurse [RN], licensed psychologist or masters degree psychologist) or one certified occupational therapy assistant and one other paraprofessional staff person. The qualified staff person(s) must be physically present throughout the group session and must perform or direct the service; and
- the supervising psychiatrist approves, signs, and dates the plan for that recipient, and reviews and signs the plan no less frequently than once every 60 days.

Covered Medical Day Treatment Services

To provide guidance to providers regarding HSS 107.13(4)(a), Wis. Admin. Code, the following are examples of services covered by the WMAP when they are specifically identified in the recipient's treatment plan as being necessary modalities toward the achievement of measurable goals and when all requirements for medical day treatment services (listed above) are met. The examples are:

- Psychiatric services including assessments, psychotherapy, and medication management. Medication management may be performed by an RN. Group services related to medication effects and side effects are also allowed services.

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B. COVERED SERVICES (continued)

- Other individual or group counseling services, supportive psychotherapy, and symptom management. Groups designed to educate the recipient about mental illness or about topics (such as AIDS), with the intent of maximizing the recipient's functioning in the community, are allowed services.
- Specific skill development in communications or problem solving. Examples would include stress management and assertiveness training.
- Specific skill development related to activities of daily living designed to enable the recipient to function at a higher level and to function independently. Examples would include personal hygiene activities, cooking, budgeting, health, and nutrition.
- Pre-employment services, which are not job-specific, to assist the recipient in gaining and using skills necessary to undertake employment. These services would include activities to reduce anxiety or to manage symptoms on the job, and education about appropriate job-related behavior.
- Other occupational, physical, social, recreational, or speech therapies, recognized in the professional literature as acceptable and effective treatments, which enable adults with acute or chronic mental illness to function with greater independence.
- Face-to-face crisis intervention services may be provided when they are consistent with the recipient's overall treatment goals, even though they are not identified in the treatment plan.
- AODA treatment and educational services may be provided to medical day treatment recipients when the staff providing the services is knowledgeable about AODA issues and is knowledgeable about the special needs of individuals who have a co-existing mental illness. However, providers must still meet the staffing requirements identified in Section I of this handbook, e.g. at least one qualified staff person must lead the service and be present in the room and throughout the group. Therefore, an AODA service may be provided directly by a master's level psychologist who is knowledgeable about AODA issues or the services may be provided conjointly by a certified AODA counsellor and an RN (or some other qualified staff person).

Completion of the functional assessment form is also a covered service whether or not the recipient is eligible for medical day treatment based on the assessment. Refer to Appendix 4 of this handbook for the appropriate procedure codes to be used for billing both positive and negative functional assessments.

C. DOCUMENTATION

The recipient's medical record must contain copies of the functional assessment and treatment plans required under HSS 107.13(4)(a), Wis. Admin. Code, and the evaluations of progress required under HSS 105.24(1)(b)3, Wis. Admin. Code. The recipient's medical record must include signed and dated notes for all services billed to the WMAP. Providers are referred to HSS 106.02(9), Wis. Admin. Code, for requirements pertaining to documentation of services.

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C. DOCUMENTATION (continued)

HSS 106.02(9)(a)1-8, Wis. Admin. Code, requires that providers document the following in the recipient's medical record:

- the full name of the recipient;
- the identity of the person who provided the service to the recipient;
- an accurate, complete, and legible description of each service provided;
- the purpose of and need for the services;
- the quantity, level, and supply of service provided;
- the date of service;
- the place where the service was provided; and
- the pertinent financial records.

Reviews of provider records have sometimes revealed that providers have not adequately documented the purpose of groups provided as a part of day treatment, the recipient's needs as they relate to the group and the specific goals the recipient is attempting to meet by taking part in the group, or the recipient's response to the group intervention. Providers who fail to provide this documentation will be out of compliance with HSS 106.02(9)(a), Wis. Admin. Code.

D. HEALTHCHECK "OTHER SERVICES"

Day treatment services as described in this handbook are limited to adults 18 years of age and older. The WMAP considers requests for medical day treatment services for individuals under 21 years of age when the following conditions are met:

- there is verification of a comprehensive HealthCheck screening prior to the request (visit verification cards which are given at the completion of a comprehensive screen are available free of charge from the State Division of Health Forms Center);
- the service is allowed under the Social Security Act (i.e., is a "medical" service);
- the service is "medically necessary" and "reasonable"; and
- a currently covered service is not appropriate to treat the identified condition.

The WMAP has developed unique policies and procedures for reimbursing mental health day treatment to children and adolescents who meet the requirements for HealthCheck Other Services. All such requests are subject to prior authorization.

Refer to Section IV of Part A of the WMAP Provider Handbook for additional information on HealthCheck "Other" Services.

E. NONCOVERED SERVICES OR RELATED LIMITATIONS

As specified in HSS 107.13(4)(d), Wis. Admin. Code, the following are not WMAP-covered medical day treatment services:

- 1. Day treatment services which are primarily recreation-oriented and which are provided in non-medically supervised settings such as 24-hour day camps, or other social service programs. These include sports activities, exercise groups, and activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours.
- 2. Day treatment services which are primarily social or educational in nature.
- 3. Consultation with other providers or service agency staff regarding the care or progress of a recipient.

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E. NONCOVERED SERVICES OR RELATED LIMITATIONS (continued)

- 4. Prevention or education programs provided as an outreach service, case-finding, and reading groups.
- 5. Aftercare programs, provided independently or operated by or under contract to boards.
- 6. Medical day treatment for a recipient with a primary diagnosis of alcohol or other drug abuse or dependence.
- 7. Day treatment provided in a recipient's home or away from the site of the day treatment program.
- 8. Court appearances except when necessary to defend against commitment.

In addition, HSS 107.13(4)(a) through (c) does not allow day treatment reimbursement for the following services or circumstances:

- 1. Day treatment services in excess of five hours a day or 120 hours a month.
- 2. Day treatment services in excess of 90 hours in a calendar year which have not been prior authorized.
- 3. Day treatment services provided to recipients with inpatient status in a hospital in excess of 20 hours per inpatient admission or to hospital inpatients not scheduled for discharge.
- 4. Day treatment services provided to recipients with inpatient status in a nursing home which have not been prior authorized. No more than 40 hours of service in a calendar year may be authorized for nursing home recipients.
- 5. Day treatment services provided to individuals who were not shown as being able to benefit from day treatment by the functional assessment.
- 6. Psychotherapy services, occupational therapy services, or other services provided as component parts of a recipient's day treatment program when these services are separately billed.
- 7. Day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy, or AODA services without prior authorization for the day treatment services.
- 8. More than two series of day treatment in one calendar year related to separate episodes of acute mental illness.
- Day treatment services provided to recipients who are receiving WMAPreimbursed community support program services.

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A. GENERAL REQUIREMENTS

Prior authorization safeguards against unnecessary utilization of care, promotes the most effective and appropriate use of available services, and assists in cost containment. Providers need prior authorization for certain specified services before delivery, unless the service is an emergency. Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

As specified in HSS 107.13(4)(b), Wis. Admin. Code, prior authorization is required from EDS prior to the provision of services for:

- Day treatment services provided beyond 90 hours in a calendar year;
- All day treatment services provided to recipients with inpatient status in a nursing home;
- All day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy or AODA services.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medical Assistance Program (WMAP) requirements, must be met prior to payment of the claim.

C. PRIOR AUTHORIZATION CRITERIA

The guidelines for prior authorization of medical day treatment services are in Appendix 10 of this handbook. The guidelines represent generally accepted parameters by which individual requests can be adjudicated. They are used along with the clinical judgement of the WMAP's mental health consultant to adjudicate prior authorization requests.

The guideline format divides the delivery of medical day treatment services into three categories:

- rehabilitation (for an initial, acute, mental health problem);
- maintenance (for a long-term, relatively stable, mental health problem); and
- stabilization (for decompensation or acute exacerbation of a long-term, mental health problem).

The guidelines are based on an analysis of actual statewide data for WMAP medical day treatment services.

Providers are reminded that WMAP consultants review and adjudicate prior authorization requests on a case-by-case basis. It is, therefore, essential that adequate explicit clinical information be provided on <u>each</u> prior authorization request. Prior authorization requests may be returned to providers for additional information when the initial request does not contain adequate information to adjudicate the request. Returned requests <u>are not denials</u>. Providers are responsible for providing adequate, <u>updated</u>, information to allow the mental health consultant to determine the appropriateness of the services being requested. The additional information must be added to the returned request, and resubmitted to EDS. Do <u>not</u> complete a new PA/RF.

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D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Providers requesting prior authorization for medical day treatment must complete the PA/RF and the prior authorization day treatment attachment (PA/DTA). Samples of the PA/RF and PA/DTA along with completion and submittal instructions are in Appendices 6, 7, 8, and 9 of this handbook.

Send completed prior authorization request forms to:

EDS
Attn: Prior Authorization Unit
Suite 88
6406 Bridge Road

Madison, WI 53784-0088

Prior authorization request forms can be obtained by writing to:

EDS
Attn: Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

E. SPECIAL CIRCUMSTANCE S AFFECTING PRIOR AUTHORIZATION

When to Request Prior Authorization

Because a provider may have no way of knowing whether or not a recipient has received services from another provider and has, therefore, reached the prior authorization threshold, providers are encouraged to request prior authorization as soon as possible when providing medical day treatment services. Because the WMAP ordinarily grants prior authorization to only one psychotherapy/AODA provider at a time, requesting prior authorization helps protect the provider against potential denial of services.

Any part of the 90 hours of service which may be reimbursed without prior authorization that is not used, is available for the recipient's use for the remainder of the calendar year.

Determination of Grant Dates

The prior authorization grant date (i.e., the first date of service which may be reimbursed under the authorization) is the date the prior authorization request is received at EDS unless the provider specifically requests otherwise. When a request is returned to the provider for additional information, the grant date does not change if returned in a timely manner.

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E. SPECIAL
CIRCUMSTANCES
AFFECTING
PRIOR
AUTHORIZATION
(continued)

Procedures for Backdating Prior Authorization Requests

Backdating of prior authorization requests up to two weeks prior to the date the prior authorization is received at EDS may be allowed at the discretion of the WMAP mental health consultant. The provider must request the backdating and must indicate the <u>clinical</u> rationale for the backdating on the prior authorization attachment or in a narrative submitted with the prior authorization request. The WMAP does not backdate requests for continuing authorization by the same provider.

Backdating for Services by Multiple Providers Exceeding the Prior Authorization Threshold

Providers may request backdating of prior authorizations to cover services which were denied because they exceeded the prior authorization threshold. In these cases, authorization may be granted for services provided more than two weeks prior to the receipt of the prior authorization request at EDS. Requests for backdating prior authorizations are considered if:

- More than one medical day treatment provider provided service during the period for which the backdating is requested; and
- The provider must document an inability to obtain information from the recipient or other provider which would have allowed the provider to determine that prior authorization would have been required.

Service Interruptions

If a provider is unable to use all prior authorized services during the prior authorization grant period due to unforeseeable interruptions in service (e.g., recipient illness or vacation), the provider may request an extension of the grant period. The provider should write a letter indicating the change requested and the reason and attach it to a copy of the approved PA/RF and send these to the EDS Prior Authorization Unit. Gaps in service exceeding one month require special justification.

If a recipient transfers to another day treatment provider before the expiration of a prior authorization period, the provider should notify the EDS Prior Authorization Unit of the exact date care is terminated so that a new prior authorization may be granted. If a provider is requesting prior authorization for a recipient who has an approved prior authorization from another provider and the other provider will not cooperate with terminating their authorization, the requesting provider should include a signed letter from the recipient indicating that he or she is no longer receiving services from the other provider. Indicate specific beginning and end dates.

* * * * * WISCONSIN MEDICAL ASSISTANCE PROVIDER HANDBOOK * * * * *					
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E. SPECIAL
CIRCUMSTANCES
AFFECTING
PRIOR
AUTHORIZATION
(continued)

Concurrent Mental Health/AODA Prior Authorizations

Prior authorization is required for all medical day treatment services for individuals receiving concurrent mental health or AODA services under HSS 107.13(4)(b)1c. Wis. Admin. Code. Individuals involved in primary AODA treatment (intensive or day treatment) will generally not be eligible for concurrent medical day treatment. Medical day treatment may be granted concurrently with outpatient psychotherapy or AODA treatment when the provider demonstrates that all three of the following conditions are met.

- 1. The recipient is diagnostically appropriate for both services.
- The providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the day treatment services augment the other outpatient services.
- 3. One of the following statements is true:
 - There is a pre-existing relationship between the recipient and the outpatient provider.
 - The recipient has appropriate day treatment needs, but the recipient also has a need for specialized intervention which the day treatment staff is not trained to provide.
 - The recipient is transitioning from day treatment to outpatient services.

In general, a recipient who is able to benefit from outpatient services will not require as high a level of day treatment services and the consultant may modify the hours requested based on his or her clinical judgement. Refer to the consultant guidelines in Appendix 10 of this handbook for additional information.

* * * * * WISCONSIN MEDICAL ASSISTANCE PROVIDER HANDBOOK * * * * *						
PART H, DIVISION III	SECTION IV	ISSUED	PAGE			
MEDICAL DAY TREATMENT	BILLING INFORMATION	04/94	3H4-001			

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP covered service. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are called dualentitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare <u>prior</u> to billing Medical Assistance.

C. QMB-ONLY RECIPIENTS

If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 2 of this handbook.

Qualified Medicare Beneficiary Only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some medical day treatment services, claims submitted for QMB-only recipients for Medicare allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

Medical day treatment services are subject to recipient copayment as noted in Appendix 4 of this handbook. The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the WMAP-allowed payment.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS Attn: EMC Department 6406 Bridge Road Madison, WI 53784-0009 (608) 221-4746

A Paperless Claims request form can be found in Appendix 3 of this handbook.

* * * * * WISCONSIN MEDICAL ASSISTANCE PROVIDER HANDBOOK * * * * *					
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E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Medical day treatment services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Medical day treatment services submitted on any other paper form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services Post Office Box 1109 Madison, WI 53701 (608) 257-6781 (Madison area) 1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to:

EDS 6406 Bridge Road Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A of the WMAP Provider Handbook.

F. DIAGNOSIS CODES

All diagnoses must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

G. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all medical day treatment claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for medical day treatment are listed in Appendix 4 of this handbook.

The functional assessment procedure codes are subject to the six hour per two year limit on mental health evaluations. Functional assessments which cause this limit to be exceeded should be billed using the limitation-exceeded functional assessment codes.

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H. PLACE OF
SERVICE AND
TYPE OF
SERVICE CODES

Allowable place of service and type of service codes for medical day treatment services are included in Appendix 5 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.

MEDICAL DAY TREATMENT PROVIDER HANDBOOK APPENDICES

		Page #
1.	Sample National HCFA 1500 Claim Forms	
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	1b. Electronic Media Claims Medical Screen	3H5-005
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11.	Sample Medical Day Treatment Functional Assessment	3H5-033
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APPENDIX 1a MEDICAL DAY TREATMENT SERVICES

1 MEDICARE MEDICAID CHAMPUS	CHAMPVA GROUP FEC.		SURANCE CL			ROGRAM IN ITEM 1)
MEDICARE MEDICAID CHAMPUS (Medicare #)	HEALTH PLAN BLK (VA File #) (SSN or ID) (SS	LUNG	123456789		(PON P	HOGHAM IN 11 EM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, Firs	t Name, Middle	initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO		7. INSURED'S ADDRE	SS (No., Street)	· · · · · · · · · · · · · · · · · · ·	
609 Willow St.	Self Spouse Child	Other				
CITY	STATE 8. PATIENT STATUS WI Supple Married		CITY			STATE
Any town; TELEPHONE (Include Are		Other	ZIP CODE	TEL	EPHONE (INC.)	UDE AREA CODE)
55555 (XXX)XXX-XX		Part-Time Student			()	OUT ALLA GODE,
9. OTHER INSURED'S NAME (Last Name, First Name, Middle OI-P			11. INSURED'S POLIC	Y GROUP OR I	FECA NUMBER	1
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT C	OR PREVIOUS)	a. INSURED'S DATE C	F BIRTH		SEX
	YES [NO	MM DD	YY	M 🔲	F 🔲
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME	OR SCHOOL	NAME	
M	C. OTHER ACCIDENT?]NO	- AICHDANGS DI	HAME OF BET	CDAMA *****	
C. EMPLOYER'S NAME OR SCHOOL NAME		NO	C. INSURANCE PLAN I	WARE OH PHO	GRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL U	J	d. IS THERE ANOTHE	R HEALTH BEN	IEFIT PLAN?	
			YES	NO If yes	, return to and c	omplete item 9 a-d.
READ BACK OF FORM BEFORE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of government below.			INSURED'S OR AU payment of medical services described in	benefits to the		TURE I authorize ysician or supplier for
SIGNED	DATE		SIGNED			
14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR	15. IF PATIENT HAS HAD SAME OR S GIVE FIRST DATE MM DD	SIMILAR ILLNESS.	16. DATES PATIENT U	NABLE TO WO	MM	
PREGNANCY(LMP) 7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		1	FROM 18. HOSPITALIZATION	1	то	
I. M. Referring MD	12345678	,0.000	MM DD FROM		TO MM	DD YY
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB?	_1	\$ CHARGES	
			<u> </u>	NO ON		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RE	LATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUB CODE	MISSION ORK	GINAL REF. NO).
1. <u>296.5</u>	3	•	23. PRIOR AUTHORIZ	ATION NUMBE	R	
2	4					
24. A B C	D	E	F	G H	I J	K
DATE(S) OF SERVICE Place Type of of of	(Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	OR Family	EMG COB	RESERVED FOR LOCAL USE
			VV VV			
01 03 92	1.W8913		XX XX	1.0	 	
01 10 92 14 16 2 1	W8911 "	1	XX XX	3.0		
01 21 92 2 1	W8911	1	xx xx	1.5		
	2					
		<i>?</i>		 		
						spenddown XX.XX
•	i (For govt.	ASSIGNMENT? claims, see back)	28. TOTAL CHARGE	1	OUNT PAID	30. BALANCE DUE
	1234JED YES	NO NO		XX s	XX XX	s XX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	. NAME AND ADDRESS OF FACILITY WHERE S RENDERED (If other than home or office)	SERVICES WERE	33. PHYSICIAN'S, SUF & PHONE #		NG NAME, ADD	PRESS, ZIP CODE
I.M.Authorized MM/DD/YY			I. M. E 1 W. Wi			
SIGNED DATE			Anytown		555	76543210

APPENDIX 1b -- ELECTRONIC MEDIA CLAIMS MEDICAL SCREEN

MEDICAL ECS SCREEN

The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form.

		WELCO	ME TO				IS SUBMIS INSIN MED			DATE	010493	
PCN RP N	BR 33 26 BR 21.1	17	OI 9	TPL	<u>10</u> 32	MSC 1 _ OP	NBR	R	23	MID LAB2	1A 0	
DTL	FDOS	A1A2A3	POS	PROC	Ml	M2	PP NBR	DX	CHARGE	UNIT	TOS E	MG H/F
2												
T	OT BILL	28 0	I PAID	29	P	AT PA	ID24.	K N	ET BILL	30		

Doc #1 Page #1 Field #5 Form: MEDICAL/MEDVENDR 01-04-1993 14:59:02

BENEFITS OF ELECTRONIC BILLING

One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data element that are not required on electronic claims include:

- claim sort indicator
- patient's sex
- patient's date of birth
- signature of provider
- patient's address
- provider's name and address

Other benefits of billing electronically include:

- free software

- flexible submission methods
- improved cash flow
- claim entry controlled by provider
- lower detail denial rate
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at:

EDS Attn: EMC Department 6406 Bridge Road Madison, WI 53784-0009 (608) 221-4746 WMAP Provider Handbook, Part H, Division III

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APPENDIX 2 NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter the appropriate claim sort indicator "P" in the Medicaid check box. Claims submitted without the appropriate indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER

Enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Health insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

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limited to:

OI-Y

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the <u>first</u> box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c and 9d are not required.)

Code Description OI-P PAID in part by health insurance. The amount paid by health insurance to the provider or the insured is indicated on the claim. OI-D DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.

- Recipient denies coverage or will not cooperate;
- The provider knows the service in question is noncovered by the carrier;

YES, the card indicated other coverage but it was not billed for reasons including, but not

- Insurance failed to respond to initial and follow-up claim; or
- Benefits not assignable or cannot get an assignment.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

<u>Important note:</u> The provider may <u>not</u> use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services provided by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

The <u>first</u> box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed for covered services prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

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Code Description
 Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.

- M-5 Provider not Medicare certified for the benefits provided.
- M-6 Recipient not Medicare eligible.
- M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
- M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amount on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN

When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

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ELEMENT 23 - PRIOR AUTHORIZATION

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed have the same procedure code.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for each procedure is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE

Enter the appropriate WMAP single-digit place of service code for each service.

Numeric Description Outpatient H

- 2 Outpatient Hospital
- 3 Office

ELEMENT 24C - TYPE OF SERVICE CODE

Enter the appropriate single-digit type of service code.

Code Description1 Medical Services (Medical Day Treatment)

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Indicate the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes.

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ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. Use a decimal when a fraction of a whole unit is billed.

Minutes Billed Quantity		Minutes Billed	Quantity
1-6	.1	31-36	.6
7-12	.2	37-42	.7
13-18	.3	43-48	.8
19-24	.4	49-54	.9
25-30	.5	55-60	1.0

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure that was performed as a result of to a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

ELEMENT 24I - EMG

Enter an "E" for <u>each</u> procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

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ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, indicate "OI-P" in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 3 PAPERLESS CLAIMS REQUEST FORM

Plo	ease complete	e this form if you want additional inform	ation on electronic billing.	
Na	me:			
Ad	dress: _			
	-			
		ber: Phone #:		
		II		
		(s) Provided: thly Medicaid Claims Filed:		
2.00		may measure crams then		
• •	• • • • •	• • • • • • • • • • • • • • • • • • •		• • • • • • •
1.	Do you cu	rrently submit your Medicaid claims on p	paper?	_YES _NO
2.	Are your !	Medicaid claims computer generated on p	paper?	_YES _NO
3.	Do vou us	e a billing service?		_YES _NO
	•	ver is YES to #2 or #3, please complete	the following:	
	Name:		-	
	Address:		Phone #:	
4.	If YES, typ	ve an in-house computer system? De of computer system:	N	_YES _NO
	•	main frame	Manufacturer: _	
	` -	IBM 360, Burroughs 3800)	Model #: Manufacturer:	
		Computer IBM System 34, or 36 TI 990)	Manufacturer: _	· · · · · · · · · · · · · · · · · · ·
	_	-Computer	Manufacturer:	
		IBM PC, COMPAQ, TRS 1000)	Model #:	
		·	_	
5.	Please send	the paperless claims manual for:		
		magnetic tape submission		
		telephone transmission (EDS fre	ee software) 3-1/2*	5-1/4"
		telephone transmission (3780 pro	otocol transmission)	
Retu	orn To:	EDS Attn: EMC Department 6406 Bridge Road Madison, WI 53784-0009		

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APPENDIX 4 HCPCS PROCEDURE CODE AND COPAYMENT TABLE FOR MEDICAL DAY TREATMENT SERVICES

Procedure Code	Description	Copayment
W8910	Day Treatment Inpatient Recipient (1 hour)	\$.50/day
W8911	Day Treatment Outpatient Recipient (1 hour)	\$.50/day
W8912	Day Treatment Nursing Home Recipient (1 hour)	\$.50/day
W8913	Functional Assessment Positive Dx (1 hour)	\$.50/day
W8914	Functional Assessment Negative Dx (1 hour)	\$.50/day
W8988	Limitation-Exceeded Functional Assessment (POS)/1 hour	\$2.00/hour
W8989	Limitation-Exceeded Functional Assessment (NEG)/1 hour	\$2.00/hour

APPENDIX 5 WMAP ALLOWABLE PLACE OF SERVICE (POS) AND TYPE OF SERVICE (TOS) CODES FOR MEDICAL DAY TREATMENT SERVICES

PLACE OF SERVICE CODES

Code	Description			
2	Outpatient Hospital			
3	Office			

TYPE OF SERVICE CODE

<u>Code</u>	<u>Description</u>				
1	Medical Services (medical day treatment)				

APPENDIX 6 PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO: E.D.S. FEDERAL CORPORTION AUTHORIZATION 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-00 2 RECIPIENT'S MEDICAL ASSIST 1234567890 3 RECIPIENT'S NAME (LAST. FIR RECIPIENT'S NAME (LAST. FIR RECIPIENT, Im 5 DATE OF BIRTH MM/DD/YY 7 BILLING PROVIDER NAME, ADI I. M. Provider 1 W. Williams Anytown, WI	N UNIT D88 ANCE ID NU ST, MIDDLE I A.	INITIAL)	6 SEX		THORIZATION REC	4 RECIPIENT 609 Anyte	ADDRESS (STREET Willow own, WI 555 OMDER TELEPHON) XXX - XX 9 BILLING PROVID 76543210 10 DX: PRIMARY 295.3 - 11 DX: SECONDAF 301.8 - 12 STARTI DATE OF	COTY. STATE 555 E NUMBER XX ER NO. schizoph Y passive	129 ZIP COD	a
14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18	DESCRIPT	TON OF SERVI		19	20	CHARGES
W8911	+		<u> </u>	 		ION OF SERVI	<u> </u>	QR	-	CHARGES
W0311	<u> </u>	3	1	Day	Treatment			10		XXX.XX
						 		 	_	
	-			ļ					 	
	<u> </u>							<u> </u>	 	
			<u></u>	<u></u>					21	
22. An approved authorization Reimbursement is continge recipient and provider at for services initiated prior Assistance Program paymauthorized service is provided as MM/DD/YY	nt upon el the time to approv ent meth	igibility of the serval or affootogy Preimbu	of the vice is per author and Poursement	provided prization licy. If will be	expiration date.	Reimburseme enrolled in a e service is no	ent will be in ac	cordance w	ent wil	conein Medical
					NOT WRITE IN TH					
AUTHORIZATION:	,									
П						•	PROCEDURE(S) AUT	HORIZED	QUAN	TITY AUTHORIZED
APPROVED	•	GR	ANT DATE		EXPIRATION	DATE				
DENIED - REA	ISON: ISON: ISON:									
482-120 DATE		-	CO	NSULTANT	T/ANALYST SIGNATUR	E				

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APPENDIX 7 PRIOR AUTHORIZATION REQUEST FORM (PA/RF) COMPLETION INSTRUCTIONS

ELEMENT 1 - PROCESSING TYPE

Enter "129".

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Indicate the recipient's 10-digit Medical Assistance identification number from the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME

Indicate the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS

Indicate the address of the recipient's place of residence; the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH

Indicate the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX

Indicate an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE

Indicate the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be indicated in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER

Indicate the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

Indicate the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS

Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service requested.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS

Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)

Indicate the appropriate procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

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ELEMENT 16 - PLACE OF SERVICE

Indicate the appropriate place of service code designating where the requested service would be provided.

<u>Code</u>	Description				
2	Outpatient Hospital				
3	Office				

_

ELEMENT 17 - TYPE OF SERVICE

Indicate type of service code "1" to signify medical day treatment services.

ELEMENT 18 - DESCRIPTION OF SERVICE

Indicate a written description corresponding to the appropriate procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED

Indicate the number of hours for each service requested.

ELEMENT 20 - CHARGES

Indicate your usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Indicate this total in element 20.

NOTE: The charges indicated on the <u>request form</u> should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to <u>Terms of Provider Reimbursement</u> issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE

Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT

"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance managed care program at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the managed care program."

ELEMENT 23 - DATE

Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE

The signature of the provider requesting the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 8 PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION Prior Authorization Unit Suite 88 6406 Bridge Road Madison, WI 53784-0088

PA/DTA

PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT

- 1. Complete this form
- 2. Attach to PA/RF (Prior Authorization Request Form)
- 3. Mail to EDS

RECIPIENT INFORMATION (1)	(2)	(3)		
		<u> </u>	(4)	5
Recipient	Int	A	1234567890	29
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE
PROVIDER INFORMATION				
6	7		8	
I. M. Requesting	76543210		(_{XXX}) _{XXX} - _{XXX}	Y
REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS		REPROVIDER'S NCE PROVIDER NUMBER	REQUESTING/PERFORMING PR	OVIDER'S
9		10		
I. M. Refe	erring	12345678		
	RRING/PRESCRIBING OVIDER'S NAME	REFERRING/PRESCR ASSISTANCE	HIBING PROVIDER'S MEDICAL PROVIDER NUMBER	

- A. Number of hours per week requested 10 hrs/wk
- B. Estimated final treatment date 12/92 and after
- C. Has the recipient had previous Day Treatment at your facility or elsewhere?
 ☑ Yes □ No □ Unknown
 If "Yes", list dates and locations:

Client began Day Treatment on DD/MM/YY and has had 6 months of intensive treatment.

D. Evaluation(s): (Dates, Tests Used and Results)

MM/DD/YY functional assessment MM/DD/YY psychiatric interview MM/DD/YY clinical interview

- E. Attach page one (1) of the recipient's most recent Function Assessment Scales. (Functional Assessment must be signed and dated within 3 months of receipt by EDS)
- F. Is the recipient's intellectual functioning below average?

 ☐ Yes 图 No
 If "yes", what is the recipient's IQ score or intellectual functioning level, and how was this measured?

G. Provide a brief history, pertinent to requested services (include psycho-social history, hospitalization history, family history, living situation history, etc.).

According to available records this client has been in and out of institutions for 10 years. The active phase of her illness occurred 10 years ago. Client throughout her history has shown bizarre decisions, auditory hallucinations, loosening of associations, and inappropriate affect. This client while in the active phase, has pulled a knife on her family which warranted an emergency detention. This occurred I year ago. As a result, client was placed in a group home after being stabilized in the hospital. Her family currently has decided not to be involved with her.

H. Progress/status since treatment began or was last authorized:

Client is currently stabilized with medication. However periodic auditory hallucinations appear to be occurring. Client has been able to perform vocational tasks through our workshop and participates in this 2 days/wk. under stress client has a high potential of having an exacerbation of psychotic symptoms. With continued support she has been able to remain in the community.

l.	Specify	overall	character	of	service	to	be	provided:
----	---------	---------	-----------	----	---------	----	----	-----------

J. Identify measurable treatment goals:

- 1) The major goal of Day Treatment is to help maintain this client in the community. This will be measured by a decrease in hospitalizations.
- 2) Client will be supported for acceptance of her disease by continued willingness to take medications, and continued verbalizations of this in a group. This will also be measured by regular attendance in all groups.
- 3) Client will continue to learn ADL skills and problem solving skills. This will be demonstrated by increased independence in her group home and at her vocational placement.
- 4) Client will be monitored for changes in emotional, social, and task skills as measured by functional assessment.

K.	Attach a specific schedule of activities, to include day, time of day, length of session and service to be provided: See Attachment
L.	Rehabilitation Potential: estimate the recipient's potential for Employment (competative, supported, sheltered, etc.) Social Interaction, Independent Living
	It appears that client has reached maximum potential at this time. Because of the chronic nature of her illness, client's potential for employment is poor. However, with consistent structure, her potential placement in a sheltered workshop and independent living situation is good.
_	
M	. Recipient Authorization I have read the attached request for prior authorization of Day Treatment services and agree that it will be sent to the Medicaid Program for review.
	Signature of Recipient or Representative Relationship (If representative, state relationship to recipient)
_	THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).
N.	Signature of Prescribing Physician Date

Signature of 51.42 Board Director/Designee

MM/DD/YY

Date

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APPENDIX 9 INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS Attn: Prior Authorization, Suite 88 6406 Bridge Road Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) or the Prior Authorization Day Treatment Attachment (PA/DTA) may be addressed to EDS' Correspondence Unit for Policy/Billing Information. Refer to Appendix 2 of Part A of the Wisconsin Medical Assistance Program (WMAP) provider handbook for the telephone numbers.

RECIPIENT INFORMATION

ELEMENT 1 - RECIPIENT'S LAST NAME

Indicate the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME

Indicate the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL

Indicate the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER

Indicate the recipient's ten-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE

Indicate the age of the recipient in numerical form.

PROVIDER INFORMATION

ELEMENT 6 - REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS

Indicate the name and the credentials of the provider requesting prior authorization.

ELEMENT 7 - REQUESTING/PERFORMING PROVIDER NUMBER

Indicate the eight-digit Medical Assistance provider number of the provider requesting prior authorization.

ELEMENT 8 - REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER

Indicate the telephone number, including area code, of the requesting provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME

Indicate the name of the referring/prescribing provider.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

Indicate the eight-digit Medical Assistance provider number of the referring/prescribing provider.

"Day Treatment" or "Day Hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies and follow-up services, to alleviate problems related to mental illness or emotional disturbances. Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills." HSS 101.03(37).

The target population for extended day treatment services are the chronically mentally ill (CMI) or those that have an acute exacerbation of a chronic mental disorder (supported by diagnosis and narrative summary).

Rehabilitation

This category is used for all of the target day treatment population who may benefit by intensive day treatment.

Maintenance

This category is for those recipients, who by diagnosis and history, are suffering from a <u>chronic mental disorder</u> as indicated by diagnosis, signs of illness for two or more years, and past intensive day treatment has already been tried for six months, or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to <u>maintain</u> the individual in the community and prevent hospitalization.

Stabilization

This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure to stabilize the recipient, to prevent harm to self and/or others, and/or to prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) and/or other acceptable signs of clear deterioration (in level and course of functioning).

The remaining portions of this attachment are to be used to document the justification for the service requested.

- 1. Complete elements A-N. The recipient's signature in element M is optional. The signature of the 51.42 Board Director, in element N, is not required.
- 2. Attach a photocopy of the demographic sheet of the functional assessment form to this attachment.
- 3. Attach a photocopy of the physician's current prescription for medical day treatment to the attachment form. The prescription must be dated within one month of receipt by EDS.
- 4. Read the Prior Authorization Statement before dating and signing the attachment.
- 5. The attachment must be dated and signed by the provider requesting or providing the service.

APPENDIX 10 GENERAL CONSULTANT GUIDELINES FOR PRIOR AUTHORIZATION OF MEDICAL DAY TREATMENT SERVICES

- 1. The target population for extended day treatment services are the chronically mentally ill (CMI) or those that have an acute exacerbation of a chronic mental disorder (supported by diagnosis and narrative summary).
- 2. Diagnostic limitations (DSM-III-R) for medical day treatment services are:
 - a. Acceptable diagnoses
 - <u>Certain Psychoses</u> 295 (Schizophrenic Disorders), 296 (Affective Psychoses), and 298 (Other Nonorganic Psychoses).
 - Other Disorders 301 (Personality Disorders) and 311 (Depressive Disorder, not elsewhere classified).
 - b. Possible diagnoses (with careful scrutiny) 300 (Neurotic Disorders), usually limited to 300.11, 300.3, 300.4, 300.81, and 300.9 (the narrative must document interference in life functioning).
 - c. All other diagnoses are deemed inappropriate for medical (generic) day treatment (i.e., 290-294, 297, 299, 302-310, 312-316). An explanation must be documented and may be approved at the consultant's discretion.
- 3. The request must include a Functional Assessment, completed within three months of the request's internal control number (ICN) date. Requests not meeting this criteria should be returned to the provider. (Refer to HSS 107.13(4)(b)f, Wis. Admin. Code, for more information.)
- 4. A recipient must have at least a 50 percent likelihood to benefit from day treatment in order to qualify for Medical Assistance reimbursement, as indicated in the Functional Assessment.
- 5. The recipient must be 18 years of age or older to qualify for day treatment services covered by these guidelines.
- 6. Those recipients suffering from acute mental illness (AMI) or a mild mental disorder (i.e., by diagnosis and history are not suffering from a chronic malady) are generally eligible for hours of treatment preceding the prior authorization threshold. Additional hours may be approved at the consultant's discretion.
- 7. A recipient with 317 (Mental Retardation) as the only or as the primary diagnosis is not eligible for day treatment services.
- 8. A recipient whose I.Q. is 65 or less is not ordinarily eligible for day treatment services. The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.
- 9. A recipient who, according to the documentation submitted, is currently abusing alcohol or other drugs is generally not eligible for medical day treatment services. Day treatment may be approved at the consultant's discretion if evidence of concurrent AODA treatment is presented. However, no intensive outpatient AODA and day treatment may be approved concurrently.

- 10. A recipient who, by narrative description, is primarily a victim of parental/relationship alcoholism, drug abuse, physical abuse, sexual abuse, or incest, is not generally eligible for generic day treatment services.
 - The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.
- 11. A recipient who, by narrative description, has an identified eating disorder, sexual addiction, or other compulsive/addictive malady, is not generally eligible for generic day treatment services.
 - The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.
- 12. The following categories with hour and time limitations, along with consultant knowledge of the recipient's needs, provider and program offered, are to be used in deciding authorization for the target populations. (Refer to numbers 1 and 2 above.)
 - a. <u>Rehabilitation</u>: This category is used for all of the target day treatment population who may benefit by intensive day treatment. Recipients believed to be in this category would receive, at the consultant's discretion, the following:
 - Threshold hours;
 - One authorization extension for six months (if requested) of up to 25 hours per week; and
 - Two additional authorization extensions of 10 to 25 hours per week for three months, IF and only IF:
 - 1) Improvement is shown in the Functional Assessment scores (i.e., LOF and COF);
 - 2) A plan is developed to transfer the recipient to ongoing community support, vocational rehabilitation, therapeutic living arrangement, etc.;
 - 3) There is evidence this process will be completed within one year (e.g., indicated by termination date, previous performance, rehabilitation potential, and narrative history); and
 - 4) The narrative indicates that, in the judgement of the provider, rehabilitation potential is "good," or better.
 - b. Maintenance: This category is for those recipients who, by diagnosis and history, are suffering from a chronic mental disorder as indicated by diagnosis, signs of illness for two or more years, and past intensive day treatment has already been tried for six months, or more with no apparent change in Functional Assessment, or narrative history. The major goal of treatment here is to maintain the individual in the community, and prevent hospitalization. Recipients in this category would receive, at the consultant's discretion, the following:
 - Authorization extension for 1 to 6 hours per week, for as long as needed (extension length up to 12 months, or the remainder of the calendar year, if requested).
 - Authorization extension may also be granted for 6 to 10 hours per week, for 3 to 12 months (or the balance of the calendar year), depending on the recipient's needs, consultant knowledge of the provider, and the provider's day treatment program.
 - c. <u>Stabilization</u>: This category is for those recipients in the target population who decompensate or have an acute exacerbation of a chronic condition. The goal in this category is to "increase structure," stabilize the recipient, and prevent harm to self or others, and prevent hospitalization.

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Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) or other acceptable signs of clear deterioration in level and course of functioning. The recipient in this category would receive, at the consultant's discretion, the following:

- Initially an extension of up to 25 hours per week, for a single three-month period.
- Following this, one extension returning to maintenance level (1-10 hours per week), unless rehabilitation potential is clearly demonstrated.
- 13. Other general considerations for determining medical day treatment hours and eligibility are, at the consultant's discretion, as follows:
 - a. The Level of Functioning score (LOF) must be between 3 and 12 to be eligible for day treatment.
 - b. The Course of Functioning score (COF) must be between 5 and 12 to be eligible for day treatment.
 - c. If the COF is greater than 12, then the risk of hospitalization needs to be at least 75 per cent to be eligible.
 - d. If the recipient is in a therapeutic or supportive working and living arrangement (i.e., CBRF, sheltered workshop, group home, foster home, or intact family), then fewer hours are indicated for day treatment.
 - e. Discharge from one day treatment program to a vocational rehabilitation (sheltered workshop) setting prohibits another intensive day treatment series, unless other criteria are met.
 - f. A recipient who is involved in primary Alcohol and Other Drug Abuse Treatment (AODA) is not generally eligible for medical day treatment services. However, if the recipient has completed primary AODA treatment and is in an after-care service, he or she is eligible for concurrent medical day treatment, at the consultant's discretion. The hours granted would generally fall into the Maintenance category.
 - g. The following activities are <u>not covered</u> as medical day treatment hours: meal times, rest periods, transportation, recreation, entertainment, and off-site visits and activities.

APPENDIX 11 SAMPLE MEDICAL DAY TREATMENT FUNCTIONAL ASSESSMENT

P	Reciplent	's Nime <u>In</u>	A. Rec	0/1/91 /1/92 ipient	
MEDICAL DAY TREATMENT DEMOGRAPHIC AND CLIENT INFORMATION	2) Client has initial as		hours of d	ay treatment since	
NAME: Last, First, Initial		SEX	BIRTHDATE:	Month, Date, Year	
Recipient, Im A.	(4) n () F (X)	(5) MM/D	D/YY	
ADDRESS: Street, City/Village/Town, (County, State	e, 21p		Telephone	
609 Willow Anytown.	WI _	55555		(7)	
REFERRAL SOURCE: 1 2 3 4 5 6 7 8*		Agency	Address	Telephone	
				(9)	
PRESCRIBING PHYSICIAN: Name		Address		Telephone	
) I. M. Physician			ţ	(11)	
		NAME OF FAC	ILITY/ADDRESS		
Client Presently Hospitalized? Yes (Client Presently Living in) No (X)	(13)		(14) Since Discharge	
) No (X)			Date	
1101	AL LIVING AF	DANCEMENT			
 () Alone () Household with spouse and other relatives or with other relatives (X) Group quarters, other than a heal related facility 	()	Household w	ith spouse onlith non-relati		
			REASON FOR	REFERRAL	
102/567000		17) To s		acting out be	havior
MEDICAID # 1234567890 ssis #				I. Also to i	
TIS #		copi	ng skills	S .	
ELIGIBILITY DECISION CRITERIA		CURRE	T SERVICES BE	ING RECEIVED	
	() No (X)	1 ´	al and Non-me ho Therar	eutic Groups,	skills
)2. MR Primary Diagnosis Yes	() No (X)	grou	p(coping)	etc.	medicati
•					
)3. ICD-9: Primary Diagnosis # $\frac{295}{301}$. Secondary & Other # $\frac{301}{301}$.		1/ n 1 ———	Nurse	RN	
)4. Total Score LOF (pages 2-4).30353					
)5. Likelihood of Benefit (page 5):	$\frac{902}{}$	1	ire of Assesso		
			Director		
6. Course of Functioning Score (page 5): <u>8</u>	1	of Functional ent Program Di	Assessment by Day	
7. Risk of Hospitalization (page 5):	<u>85, z</u>				
		Signatu	ire		
Pursuant to the provisions of HSS 105. assessment and I verify that the servi		is. Adm. Co		iewed this functional	
	which	aa ey the Di			
BY: SIGNATURE			ITLE	DATE	N/A
)				DATE	
APPROVAL GIVEN FOR: / / Functional Assessment *REFERRAL SOURCE CODE:		ion of /	/ Submission (
*REFERRAL SOURCE CODE: (1) Hospital (3) Friend	· · · · · · · · · · · · · · · · · · ·	(5) Self	(7) P	ivsician	
(2) Family (4) Agency		(6) Nursing		•	

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P				

()	Initial Asses	ssaent - (Pat	e) _ <u>]</u> [/1/91
()	Reassessment	- (Date) 4	1/92	
R	ec:	lpient's Name			

LEVEL OF FUNCTIONING TASK ORIENTATION SCALE

Note: You must know first hand or have it reliably documented that the client has actually done the tasks.

Indicators:

- a. Degree of self-application (concentration, follow through, assuming responsibility) and if necessary, the amount of guidance (instruction in performance) and support (reinforcement, reassurance) needed to maintain functioning.
- b. Relationship of level of stress to task functioning and the amount of support needed to engage or re-engage in tasks.

 a. Cannot apply self to any task for any period of time. Demonstrates no goal directed behavior. May wonder aimlessly. Guidance and support have no effect on task functioning.

- b. Cannot cope with any stress.
- a. Rarely concentrates. When alone, rarely follows through with tasks. In a highly structured situation with others very limited task follow through even with constant guidance and support.
 - b. Functioning breaks down with slightest stress. Needs much support to re-engage.
- Concentrates intermittently. When alone, limited follow through with continuous support; no guidance necessary.
 - (b.) With low stress task functioning breaks down. Support needed to re-engage.
- 4. a. Concentrates fairly consistently. At times able to follow through. Occasionally assumes responsibility for tasks, when requested to do so, if support is provided.
 - b. With low stress, task functioning is usually diminished. Support needed to re-engage.
- a. Follows through frequently and voluntarily assumes responsibility for tasks. Occasionally needs support.
 - b. With low stress, functioning will occasionally be impaired. With moderate stress, functioning will almost always be impaired. Usually needs support to re-engage.
- a. Concentration is consistent and purposeful. Follows through well and often assumes responsibility for tasks, only requiring support when under stress.
 - b. With moderate stress, functioning is usually impaired. Can re-engage by self.
- 7. a. Concentration is almost always consistent and purposeful. Follows through very well and is actively responsible in relation to tasks. Usually follows through even with frustrating tasks. Task mastery is experienced as valuable and satisfying. Very seldom needs support.
 - With moderate stress can maintain functioning. With high stress functioning is impaired, but can re-engage by self.
- 8. a. Excellent concentration and achievement orientation. Very seldom subject to distraction. Follows through even with the most frustrating tasks. Almost never needs support.
 - b. With high stress, functioning only slightly impaired. Can re-engage by self.

John Williams, M.A., Framingham Day Hospital, Framingham, Massachusetts, with consultation from Iris Carroll, O.T.R., H.P.H., Framingham Day Hospital and Fred Altaffer, Ph.D., Massachusetts Department of Mental Health, August, 1979. Copyright applied for; reproduction by an process without permission violates copyright laws.

COMMENTS

3

W	D	F	2	Piige
М	T	A	80	3
A				
Р				

() Initial A	sessment - (Date) <u>10/1/91</u>
() Reassessm	nt - (Date) 4/1/92
Recipient's N	me

LEVEL OF FUNCTIONING SOCIAL FUNCTIONING SCALE

NOTE: Social interaction can be in or out of the program. You must know of its occurrence first hand or it must be reliably documented. Social interaction with staff is not to be taken into consideration when rating.

Indicators:

- a. Ability to initiate interpersonal contact.
- b. Degree of conversational interaction.
- Degree of comfort in interpersonal situations.
- Relationship between level of stress and social functioning. Amount of support needed to engage or re-engage.
- 1. a. Does not initiate contact. When approached, no response.
 - b. Shows no ability to listen or respond in conversation.
 - c. Extreme discomfort being with others.
 - d. Unable to cope with any stress.
- 2. a. Very rarely initiates contact. When approached, sometimes responds.
 - b. Rarely listens. Responses not appropriate to conversation flow (lack of continuity, coherence).
 - c. General discomfort with others most of the time.
 - d. With the slightest stress functioning breaks down. Needs support to re-engage.
- 3. a. Rarely initiates contact. If approached, almost always responds.
 - b. Sometimes listens Responses occasionally appropriate to conversation flow.
 - (c) Discomfort with others but can tolerate limited supported interaction.
 - (d.) With low stress, functioning almost always breaks down. Needs support to re-engage.
- 3.5

COMMENT

- 4. (a) Sometimes initiates contact. Always responds.
 - (b) Usually listens. Responses often appropriate with some sharing in the conversation flow.
 - c. Some discomfort but with support can tolerate most interactions.
 - d. With low stress, functioning at this level usually diminishes. Needs support to re-engage.
- 5. a. Often initiates contact.
 - b. Can listen well. Usually responds in shared way to the conversation flow.
 - c. Usually comfortable with others in interactions that are not stressful.
 - d. Under low stress, functioning occasionally breaks down. With moderate stress functioning will almost always be impaired. Usually needs support to re-engage.
- 6. a. In most cases can initiate contact.
 - b. Listens very well. Responds in shared way to conversation flow. At times actively shapes conversation.
 - c. Usually comfortable in most interactions.
 - d. With moderate stress, functioning is occasionally impaired. Can re-engage by self.
- 7. a. Almost always able to initiate contact as desired.
 - b. Listens with empathy. Not only responds but actively shapes conversation appropriately.
 - c. Not only feels comfortable, but experiences interactions as satisfying.
 - d. With moderate stress, can maintain functioning. With high stress, functioning diminishes. Can re-engage by self.
- 8. a. Initiates contacts as desired.
 - b. Listens intuitively. Responds and shapes conversation appropriately, as desired.
 - c. Not only feels comfortable, but experiences being with others as self-enhancing.
 - d. With high stress, involvement may be diminished, but client is not immobilized.

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()	Initial Asses	ssment -	(Date)	12/23	/93
()	Reassessment	- (Date))		
Re	c:	ipient's Name				

LEVEL OF FUNCTIONING EMOTIONAL SCALE

Indicators:

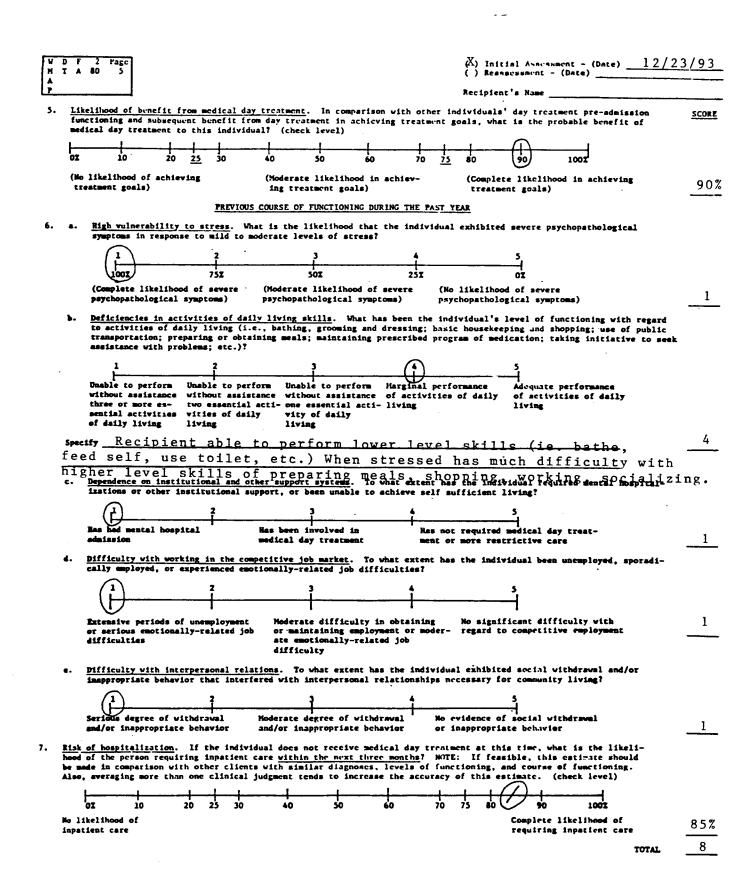
- Client's ability to be aware of and understand his emotional states.
- b. Client's relationship to his emotional states (overwhelmed? sufficiently controlled? a sense of objectivity?).
- c. Amount of support needed to function emotionally, with varying levels of stress.

COMMENT

3

- a. Emotional states appear to be either extremely controlled and rigid (flat) or extremely
 uncontrolled (labile). Cannot objectively acknowledge his emotions.
 - b. Appears severely overwhelmed by emotional experience.
 - Intervention or support has no effect. Emotional states prevent almost all everyday functioning.
- a. Although may refer to emotional states, reveals no experienced awareness or objective understanding of emotions at the time they occur.
 - b. Excessively overwhelmed by emotions.
 - Even with constant support, becomes overwhelmed with slightest stress. Needs support to regain functioning.
- 3. (a.) Indicates beginning awareness of emotional states, but anxious about this awareness.
 - (b) Emerging objectivity in relation to emotions, though frequently overwhelmed by his emotions.
 - c. Even with constant support, in low stress situations, functioning breaks down.
- a. Usually aware of emotional states. Indicates an acceptance of emotions as a necessary part
 of life. May begin to take new actions based on awareness of his emotions.
 - b. Some objectivity in relation to his emotions but often feels overwhelmed by them.
 - c. Even with frequent support, in low stress situation, functioning is diminished. Needs support to regain functioning.
- a. Indicates that he is almost always aware of his emotions and is developing an understanding of them.
 - b. Somewhat uncomfortable and overwhelmed by his emotions, but still objective enough to begin to understand them.
 - c. Even with support, emotional functioning is impaired with moderate stress. Needs support to regain functioning.
- 6. a. Understands his emotions and how they relate to everyday functioning. Begins to feel comfortable with various emotional states.
 - b. Behavior indicates sufficient emotional objectivity to function with flexibility.
 - c. Emotional functioning somewhat impaired with moderate stress. At times needs some support to regain functioning.
- a. Not only understands emotions and how they relate to everyday functioning but experiences
 this as satisfying, and a part of emotional growth.
 - In experiencing diverse emotional states, even extremes, person usually maintains a tempering objectivity.
 - c. With high stress, functioning will diminish. Occasionally needs support to regain functioning.
- 8. a. Indicates thorough understanding of his emotional life and experiences emotional growth as part of a lifelong process.
 - b. Wide variety of emotions are experienced in a larger context of emotional growth.
 - c. With high stress, functioning slightly impaired. No need for support to regain functioning.

3



APPENDIX 12 MEDICAL DAY TREATMENT DEMOGRAPHIC AND CLIENT INFORMATION COMPLETION INSTRUCTIONS

This form is the face sheet of the functional assessment scales which are required for clients in day treatment who are Wisconsin Medical Assistance recipients. This form must be completed by the day treatment staff before treatment begins, preferably by the client's case manager or by the primary staff person responsible for the person's treatment.

The form must be completed each time a functional assessment is performed. It should be kept in the client's case records. Also, a copy must be sent to the Wisconsin Medical Assistance Program (WMAP) at time of prior authorization request. Do not submit the form with claims for payment.

Print or type the information on the form, so that it is legible.

The numbers of the following items correspond to the numbers appearing on the sample form in Appendix 11 of this handbook.

- 1. <u>Initial assessment/Reassessment</u>: Check the appropriate space and indicate the date the functional assessment was performed.
- 2. <u>Client has received...</u>: Complete the statement by indicating the total number of hours of day treatment the recipient has received since the initial assessment.
- 3. Name: Print the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.
- 4. Sex: Check the appropriate space.
- 5. <u>Birthdate</u>: Indicate the recipient's birthdate in MM/DD/YY format. For example, March 21, 1959, would be written as 03/21/59.
- 6. Address: Indicate the recipient's address. If the recipient resides in a nursing home or community based residential facility, indicate the name of the facility in addition to the address.
- 7. Telephone: Indicate the recipient's home telephone number.
- 8. <u>Referral Source</u>: Circle the appropriate number corresponding to the type of referral. Refer to the referral codes in item 29 of this form for descriptions of the referral codes. Indicate the name and address of the person or agency making the referral.
- 9. <u>Telephone</u>: Indicate the referral source's telephone number.
- 10. Prescribing Physician: Indicate the name and address of the prescribing or referring physician.
- 11. Telephone: Indicate the prescribing physician's telephone number.
- 12. <u>Client Presently Hospitalized?/Living in a Nursing Home?</u> Indicate whether the client presently is an inpatient in an acute care general hospital or in a psychiatric hospital, is a resident in a nursing home.
- 13. Name of Facility/Address: If you checked "yes" to either question in item 12 of this form, indicate the name and address of the facility.

- 14. Since.../Discharge Date: If you checked "yes" to either question in item 12 of this form, then indicate the date the recipient became an inpatient or resident of the facility. Also indicate the anticipated discharge date (obtained from the facility).
- 15. <u>Usual Living Arrangement</u>: Check the appropriate space corresponding to the recipient's usual living arrangement.
- 16. Medicaid #/SSIS #/TIS #: Indicate the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

If the recipient is receiving Title XX social services through the county social services department, the recipient will have an Social Services Information System (SSIS) number. If you don't know the number, but you know the person is receiving social services (e.g., day care, supportive home care, foster care, etc.) through the county, contact the county social service office to find out the number.

All recipients will have Transitional Information System (TIS) numbers. TIS numbers are the client identification numbers used by 51.42 boards in reporting to the Department of Health and Social Services on units of services provided in a quarterly reporting period. Each recipient in your program will have a TIS number.

17.	Reason for Referral:	State briefly the major reason(s) the person was referred to day to	reatment.
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Items 18 through 24 <u>Eligibility Decision Criteria</u>: The information requested in items 18 though 24 of this form makes up the summary of data obtained through performing the complete functional assessment (pages 2-5). Based on the information contained in this section, the recipient may or may not be eligible for Medical Assistance reimbursement of the day treatment services. See the "Decision Rules for Day Treatment" for a full explanation of the criteria for eligibility.

- 18. AODA Currently: Does the recipient currently exhibit dependence on or abuse of alcohol or other drugs? Check the appropriate answer.
- 19. MR Primary Diagnosis: Does the recipient have a primary diagnosis of mental retardation? Mental retardation is defined as anyone with a diagnosis of 317, 318, or 319, according to the International Classification of Diseases 9th Revision Clinical Modification (ICD-9).
- ICD-9 Primary/Secondary Diagnosis: List the primary and secondary diagnoses according to the ICD-9.
 Do not use any other coding structure.
- 21. Total Score LOF: Indicate the three scores from the functional assessment scales in the following order:

 Task Orientation Scale, 2) Social Functioning Scale, and 3) Emotional Functioning Scale. Then add the scores for the total level of functioning (LOF) score. The score for each scale is the number of the set of statements which best describes the recipient's level of functioning.
- 22. <u>Likelihood of Benefit</u>: Indicate the answer from page 5, question 5, of the functional assessment scales.
- 23. Course of Functioning Score: Indicate the answer from page 5, question 6, of the functional assessment scales. The course of functioning score is the sum of the scores for Parts A-E.
- 24. Risk of Hospitalization: Indicate the answer from page 5, question 7, of the functional assessment scales. This item does not need to be completed unless the answer to item 23 of this form was between 13 and 25.

Issued: 04/94

- 25. <u>Current Services Being Received</u>: Indicate any services the recipient is receiving in addition to day treatment. For example, is the recipient receiving psychotherapy or occupational therapy in addition to day treatment from your facility? Does the recipient attend a sheltered workshop? Does the recipient receive social work services from the county? Does the recipient have a guardian or advocate? These are the types of services (both medical and nonmedical) that should be indicated. If this information is not known, check with the referral source, the county social service office, or the recipient's place of residence.
- 26. Name of Day Treatment Program/Signatures: Print the name of the day treatment program. The person performing the functional assessment (e.g., case manager or primary staff person) must sign and indicate his or her discipline. The day treatment program director must also sign after reviewing the assessment form.
- 27. Authorization: (not required)
- 28. Approval Given For: (not required)
- 29. Referral Source Code: These are the descriptions of the codes used in item 8 of this form.